

§ 424.5

42 CFR Ch. IV (10–1–99 Edition)

§ 424.5 Basic conditions.

(a) As a basis for Medicare payment, the following conditions must be met:

(1) *Types of services.* The services must be—

(i) Covered services, as specified in part 409 or part 410 of this chapter; or

(ii) Services excluded from coverage as custodial care or services not reasonable and necessary, but reimbursable in accordance with §§ 405.332 through 405.334 of this chapter, pertaining to limitation of liability.

(2) *Sources of services.* The services must have been furnished by a provider, nonparticipating hospital, or supplier that was, at the time it furnished the services, qualified to have payment made for them.

(3) *Recipient of services.* Except as provided in § 409.68 of this chapter, the services must have been furnished while the individual was eligible to have payment made for them. (Section 409.68 provides for payment of inpatient hospital services furnished before the hospital is notified that the beneficiary has exhausted the Medicare benefits available for the current benefit period.)

(4) *Certification of need for services.* When required, the provider must obtain certification and recertification of the need for the services in accordance with subpart B of this part.

(5) *Claim for payment.* The provider, supplier, or beneficiary, as appropriate, must file a claim that includes or makes reference to a request for payment, in accordance with subpart C of this part.

(6) *Sufficient information.* The provider, supplier, or beneficiary, as appropriate, must furnish to the intermediary or carrier sufficient information to determine whether payment is due and the amount of payment.

(b) Additional conditions applicable in certain circumstances or to certain services are set forth in other sections of this part.

[53 FR 6635, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988; 60 FR 38271, July 26, 1995]

§ 424.7 General limitations.

(a) *Utilization review finding on medical necessity.* When a PRO or a UR committee notifies a hospital or SNF

of its finding that further services are not medically necessary, the following rules apply:

(1) *Hospitals subject to PPS.* Payment may not be made for inpatient hospital services furnished by a PPS hospital after the second day after the day on which the hospital received the notice.

(2) *Hospitals not subject to PPS and SNFs—(i) Basic rule.* Except as provided in paragraph (a)(2)(ii) of this section, payment may not be made for inpatient hospital services or posthospital SNF care furnished after the day on which the hospital or SNF received the notice.

(ii) *Exception.* Payment may be made for 1 or 2 additional days if the PRO or UR committee approves them as necessary for planning for post-discharge care.

(b) *Failure to make timely utilization review.* Payment may not be made for inpatient hospital services or posthospital SNF care furnished, after the 20th consecutive day of a stay, to an individual who is admitted to the hospital or SNF after HCFA has determined that the hospital or SNF has failed to make timely utilization review in long stay cases. (This provision does not apply to a hospital or SNF for which a PRO has assumed binding review.)

[53 FR 6635, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988]

Subpart B—Certification and Plan of Treatment Requirements

§ 424.10 Purpose and scope.

(a) *Purpose.* The physician has a major role in determining utilization of health services furnished by providers. The physician decides upon admissions, orders tests, drugs, and treatments, and determines the length of stay. Accordingly, sections 1814(a)(2) and 1835(a)(2) of the Act establish as a condition for Medicare payment that a physician certify the necessity of the services and, in some instances, recertify the continued need for those services.

Section 1814(a)(2) of the Act also permits nurse practitioners or clinical

nurse specialists to certify and recertify the need for post-hospital extended care services.

(b) *Scope.* This subpart sets forth the timing, content, and signature requirements for certification and recertification with respect to certain Medicare services furnished by providers.

[60 FR 38271, July 26, 1995]

§ 424.11 General procedures.

(a) *Responsibility of the provider.* The provider must—

- (1) Obtain the required certification and recertification statements;
- (2) Keep them on file for verification by the intermediary, if necessary; and
- (3) Certify, on the appropriate billing form, that the statements have been obtained and are on file.

(b) *Obtaining the certification and recertification statements.* No specific procedures or forms are required for certification and recertification statements. The provider may adopt any method that permits verification. The certification and recertification statements may be entered on forms, notes, or records that the appropriate individual signs, or on a special separate form. Except as provided in paragraph (d) of this section for delayed certifications, there must be a separate signed statement for each certification or recertification.

(c) *Required information.* The succeeding sections of this subpart set forth specific information required for different types of services. If that information is contained in other provider records, such as physicians' progress notes, it need not be repeated. It will suffice for the statement to indicate where the information is to be found.

(d) *Timeliness.* (1) The succeeding sections of this subpart also specify the time frames for certifications and for initial and subsequent recertifications.

(2) A hospital or SNF may provide for obtaining a certification or recertification earlier than required by these regulations, or vary the time frame (within the prescribed outer limits) for different diagnostic or clinical categories.

(3) Delayed certification and recertification statements are acceptable when there is a legitimate reason for

delay. (For instance, the patient was unaware of his or her entitlement when he or she was treated.) Delayed certification and recertification statements must include an explanation of the reason for the delay.

(4) A delayed certification may be included with one or more recertifications on a single signed statement.

(e) *Limitation on authorization to sign statements.* A certification or recertification statement may be signed only by one of the following:

- (1) A physician who is a doctor of medicine or osteopathy.
- (2) A dentist in the circumstances specified in § 424.13(c).

(3) A doctor of podiatric medicine if his or her certification is consistent with the functions he or she is authorized to perform under State law.

(4) A nurse practitioner or clinical nurse specialist, as defined in paragraph (e)(5) or (e)(6) of this section, in the circumstances specified in § 424.20(e).

(5) For purposes of this section, to qualify as a nurse practitioner, an individual must—

(i) Be a registered professional nurse who is currently licensed to practice nursing in the State where he or she practices; be authorized to perform the services of a nurse practitioner in accordance with State law; and have a master's degree in nursing;

(ii) Be certified as a nurse practitioner by a professional association recognized by HCFA that has, at a minimum, eligibility requirements that meet the standards in paragraph (e)(5)(i) of this section; or

(iii) Meet the requirements for a nurse practitioner set forth in paragraph (e)(5)(i) of this section, except for the master's degree requirement, and have received before August 25, 1998 a certificate of completion from a formal advanced practice program that prepares registered nurses to perform an expanded role in the delivery of primary care.

(6) For purposes of this section, to qualify as a clinical nurse specialist, an individual must—

(i) Be a registered professional nurse who is currently licensed to practice nursing in the State where he or she practices; be authorized to perform the

services of a clinical nurse specialist in accordance with State law; and have a master's degree in a defined clinical area of nursing;

(ii) Be certified as a clinical nurse specialist by a professional association recognized by HCFA that has at a minimum, eligibility requirements that meet the standards in paragraph (e)(6)(i) of this section; or

(iii) Meet the requirements for a clinical nurse specialist set forth in paragraph (e)(6)(i) of this section, except for the master's degree requirement, and have received before August 25, 1998 a certificate of completion from a formal advanced practice program that prepares registered nurses to perform an expanded role in the delivery of primary care.

[53 FR 6634, Mar. 2, 1988, as amended at 56 FR 8845, Mar. 1, 1991; 60 FR 38272, July 26, 1995]

§ 424.13 Requirements for inpatient services of hospitals other than psychiatric hospitals.

(a) *Content of certification and recertification.* Medicare Part A pays for inpatient hospital services of hospitals other than psychiatric hospitals only if a physician certifies and recertifies the following:

(1) The reasons for either—

(i) Continued hospitalization of the patient for medical treatment or medically required inpatient diagnostic study; or

(ii) Special or unusual services for cost outlier cases (under the prospective payment system set forth in subpart F of part 412 of this chapter).

(2) The estimated time the patient will need to remain in the hospital.

(3) The plans for posthospital care, if appropriate.

(b) *Certification of need for hospitalization when a SNF bed is not available.* (1) A physician may certify or recertify need for continued hospitalization if the physician finds that the patient could receive proper treatment in a SNF but no bed is available in a participating SNF.

(2) If this is the basis for the physician's certification or recertification, the required statement must so indicate; and the physician is expected to continue efforts to place the patient in

a participating SNF as soon as a bed becomes available.

(c) *Signatures.* (1) *Basic rule.* Except as specified in paragraph (c)(2) of this section, certifications and recertifications must be signed by the physician responsible for the case, or by another physician who has knowledge of the case and who is authorized to do so by the responsible physician or by the hospital's medical staff.

(2) *Exception.* If the intermediary requests certification of the need to admit a patient in connection with dental procedures, because his or her underlying medical condition and clinical status or the severity of the dental procedures require hospitalization, that certification may be signed by the dentist caring for the patient.

(d) *Timing of certifications and recertifications: Cases not subject to the prospective payment system (PPS).* (1) For cases that are not subject to PPS, certification is required no later than as of the 12th day of hospitalization. A hospital may, at its option, provide for the certification to be made earlier, or it may vary the timing of the certification within the 12-day period by diagnostic or clinical categories.

(2) The first recertification is required no later than as of the 18th day of hospitalization.

(3) Subsequent recertifications are required at intervals established by the UR committee (on a case-by-case basis if it so chooses), but no less frequently than every 30 days.

(e) *Timing of certification and recertification: Cases subject to PPS.* For cases subject to PPS, certification is required as follows:

(1) For day-outlier cases, certification is required no later than one day after the hospital reasonably assumes that the case meets the outlier criteria, established in accordance with § 412.80(a)(1)(i) of this chapter, or no later than 20 days into the hospital stay, whichever is earlier. The first and subsequent recertifications are required at intervals established by the UR committee (on a case-by-case basis if it so chooses) but not less frequently than every 30 days.

(2) For cost-outlier cases, certification is required no later than the date on which the hospital requests

cost outlier payment or 20 days into the hospital stay, whichever is earlier. If possible, certification must be made before the hospital incurs costs for which it will seek cost outlier payment. In cost outlier cases, the first and subsequent recertifications are required at intervals established by the UR committee (on a case-by-case basis if it so chooses).

(f) *Recertification requirement fulfilled by utilization review.* (1) At the hospital's option, extended stay review by its UR committee may take the place of the second and subsequent physician recertifications required for cases not subject to PPS and for PPS day-outlier cases.

(2) A utilization review that is used to fulfill the recertification requirement is considered timely if performed no later than the seventh day after the day the physician recertification would have been required. The next physician recertification would need to be made no later than the 30th day following such review; if review by the UR committee took the place of this physician recertification, the review could be performed as late as the seventh day following the 30th day.

(g) *Description of procedures.* The hospital must have available on file a written description that specifies the time schedule for certifications and recertifications, and indicates whether utilization review of long-stay cases fulfills the requirement for second and subsequent recertifications of all cases not subject to PPS and of PPS day outlier cases.

§ 424.14 Requirements for inpatient services of psychiatric hospitals.

(a) *Content of certification and recertification: General considerations.* The content requirements differ from those for other hospitals because the care furnished in psychiatric hospitals is often purely custodial and thus not covered under Medicare. The purpose of the statements, therefore, is to help ensure that Medicare pays only for services of the type appropriate for Medicare coverage. Accordingly, Medicare Part A pays for inpatient care in a psychiatric hospital only if a physician certifies and recertifies the need for services consistent with the con-

tent of paragraphs (b) or (c) of this section, as appropriate.

(b) *Content of certification.* Inpatient psychiatric services were required—

(1) For treatment that could reasonably be expected to improve the patient's condition; or

(2) For diagnostic study.

(c) *Content of recertification.* (1) Inpatient services furnished since the previous certification or recertification were, and continue to be, required—

(i) For treatment that could reasonably be expected to improve the patient's condition; or

(ii) For diagnostic study; and

(2) The hospital records show that the services furnished were—

(i) Intensive treatment services;

(ii) Admission and related services necessary for diagnostic study; or

(iii) Equivalent services.

(d) *Timing of certification and recertification.* (1) Certification is required at the time of admission or as soon thereafter as is reasonable and practicable.

(2) The first recertification is required as of the 18th day of hospitalization. Subsequent recertifications are required at intervals established by the UR committee (on a case-by-case basis if it so chooses), but no less frequently than every 30 days.

(e) *Other requirements.* Psychiatric hospitals must also meet the requirements set forth in § 424.13 (b), (c), (f), and (g).

§ 424.15 Requirements for inpatient CAH services.

(a) *Content of certification.* Medicare Part A pays for inpatient CAH services only if a physician certifies that the individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH.

(b) *Timing of certification.* Certification is required no later than 1 day before the date on which the claim for payment for the inpatient CAH services is submitted.

[58 FR 30671, May 26, 1993, as amended at 60 FR 45850, Sept. 1, 1995; 62 FR 46035, 46037, Aug. 29, 1997]

§ 424.16 Timing of certification for individual admitted to a hospital before entitlement to Medicare benefits.

(a) *Basic rule.* If an individual is admitted to a hospital before becoming entitled to Medicare benefits (for instance, before attaining age 65), the day of entitlement (instead of the day of admission) is the starting point for the time limits specified in § 424.13(e) for certification and recertification.

(b) *Example. (Hospital that is not a psychiatric hospital and is not subject to PPS).* For a patient who is admitted on August 15 and becomes entitled on September 1—

(1) The certification is required no later than September 12;

(2) The first recertification is required no later than September 18; and

(3) Subsequent recertifications are required at least every 30 days after September 18.

[53 FR 6635, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988]

§ 424.20 Requirements for posthospital SNF care.

Medicare Part A pays for posthospital SNF care furnished by an SNF, or a hospital or CAH with a swing-bed approval, only if the certification and recertification for services are consistent with the content of paragraph (a) or (c) of this section, as appropriate.

(a) *Content of certification—(1) General requirements.* Posthospital SNF care is or was required because—

(i) The individual needs or needed on a daily basis skilled nursing care (furnished directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services that, as a practical matter, can only be provided in an SNF or a swing-bed hospital on an inpatient basis, and the SNF care is or was needed for a condition for which the individual received inpatient care in a participating hospital or a qualified hospital, as defined in § 409.3 of this chapter; or

(ii) The individual has been correctly assigned to one of the Resource Utilization Groups designated as representing the required level of care, as provided in § 409.30 of this chapter.

(2) *Special requirement: A swing-bed hospital with more than 49 beds (but fewer than 100) that does not transfer a swing-bed patient to a SNF within 5 days of the availability date.* Transfer of the extended care patient to the SNF is not medically appropriate.

(b) *Timing of certification. (1) General rule.* The certification must be obtained at the time of admission or as soon thereafter as is reasonable and practicable.

(2) *Special rules for certain swing-bed hospitals.* For swing-bed hospitals with more than 49 beds that are approved after March 31, 1988, the extended care patient's physician has 5 days (excluding weekends and holidays) beginning on the availability date as defined in § 413.114(b), to certify that the transfer of the extended care patient is not medically appropriate.

(c) *Content of recertifications. (1) The reasons for the continued need for posthospital SNF care:*

(2) The estimated time the individual will need to remain in the SNF;

(3) Plans for home care, if any; and

(4) If appropriate, the fact that continued services are needed for a condition that arose after admission to the SNF and while the individual was still under treatment for the condition for which he or she had received inpatient hospital services.

(d) *Timing of recertifications. (1) The first recertification is required no later than the 14th day of posthospital SNF care.*

(2) Subsequent recertifications are required at least every 30 days after the first recertification.

(e) *Signature.* Certification and recertification statements may be signed by—

(1) The physician responsible for the case or, with his or her authorization, by a physician on the SNF staff or a physician who is available in case of an emergency and has knowledge of the case; or

(2) A nurse practitioner or clinical nurse specialist, neither of whom has a direct or indirect employment relationship with the facility but who is working in collaboration with a physician. For purposes of this section, *collaboration* means a process whereby a nurse practitioner or clinical nurse

specialist works with a doctor of medicine or osteopathy to deliver health care services. The services are delivered within the scope of the nurse's professional expertise, with medical direction and appropriate supervision as provided for in guidelines jointly developed by the nurse and the physician or other mechanisms defined by Federal regulations and the law of the State in which the services are performed.

(f) *Recertification requirement fulfilled by utilization review.* A SNF may substitute utilization review of extended stay cases for the second and subsequent recertifications, if it includes this procedure in its utilization review plan.

(g) *Description of procedures.* The SNF must have available on file a written description that specifies the certification and recertification time schedule and indicates whether utilization review is used as an alternative to the second and subsequent recertifications.

[53 FR 6634, Mar. 2, 1988, as amended at 54 FR 37275, Sept. 7, 1989; 58 FR 30671, May 26, 1993; 60 FR 38272, July 26, 1995; 62 FR 46037, Aug. 29, 1997; 63 FR 26311, May 12, 1998; 63 FR 53307, Oct. 5, 1998]

§ 424.22 Requirements for home health services.

Medicare Part A or Part B pays for home health services only if a physician certifies and recertifies the content specified in paragraphs (a)(1) and (b)(2) of this section, as appropriate.

(a) *Certification*—(1) *Content of certification.* As a condition for payment of home health services under Medicare Part A or Medicare Part B, a physician must certify as follows:

(i) The individual needs or needed intermittent skilled nursing care, or physical or speech therapy, or (for the period from July through November 30, 1981) occupational therapy.

(ii) Home health services were required because the individual was confined to the home except when receiving outpatient services.

(iii) A plan for furnishing the services has been established and is periodically reviewed by a physician who is a doctor of medicine, osteopathy, or podiatric medicine, and who is not precluded from performing this function under paragraph (d) of this section. (A doctor

of podiatric medicine may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under State law.)

(iv) The services were furnished while the individual was under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine.¹

(2) *Timing and signature.* The certification of need for home health services must be obtained at the time the plan of treatment is established or as soon thereafter as possible and must be signed by the physician who establishes the plan.

(b) *Recertification.* (1) *Timing and signature of recertification.* Recertification is required at least every 2 months, preferably at the time the plan is reviewed, and must be signed by the physician who reviews the plan.

(2) *Content and basis of recertification.* The recertification statement must indicate the continuing need for services and estimate how much longer the services will be required. Need for occupational therapy may be the basis for continuing services that were initiated because the individual needed skilled nursing care or physical or speech therapy.

(c) [Reserved]

(d) *Limitations on the performance of certification and plan of treatment functions.* (1) *Basic rule.* Beginning November 26, 1982, and except as provided in paragraph (e) of this section, need for home health services to be provided by an HHA may not be certified or recertified, and a plan of treatment may not be established and reviewed, by any physician who has a significant ownership interest in, or a significant financial or contractual relationship with, that HHA.

(2) *Significant ownership interest.* A physician is considered to have a significant ownership interest in an HHA if he or she—

(i) Has a direct or indirect ownership interest of 5 percent or more in the

¹As a condition of Medicare Part A payment for home health services furnished before July 1981, the physician was also required to certify that the services were needed for a condition for which the individual had received inpatient hospital or SNF services.

capital, the stock, or the profits of the home health agency; or

(ii) Has an ownership interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation that is secured by the agency, if that interest equals 5 percent or more of the agency's assets.

(3) *Significant financial or contractual relationship.* Beginning November 26, 1982, a physician is considered to have a significant financial or contractual relationship with an HHA if he or she—

(i) Receives any compensation as an officer or director of the HHA; or

(ii) Has direct or indirect business transactions with the HHA that, in any fiscal year, amount to more than \$25,000 or 5 percent of the agency's total operating expenses, whichever is less. Business transactions means contracts, agreements, purchase orders, or leases to obtain services, supplies, equipment, and space and, after August 29, 1986, salaried employment.

(4) *Exemption of uncompensated officer or director.* A physician who serves as an uncompensated officer or director of an HHA is not precluded from performing physician certification and plan of treatment functions for that HHA.

(e) *Exceptions to limitations.* (1) *Exceptions for governmental entities.* The limitations of paragraph (d) of this section do not apply to an HHA that is operated by a Federal, State, or local governmental authority.

(2) *Exception for sole community HHAs.* The limitations of paragraph (d) of this section do not apply on or after the date on which the HHA is classified as a sole community HHA in accordance with paragraphs (f) and (g) of this section.

(f) *Procedures for classification as a sole community HHA.* (1) The HHA must submit to its intermediary a request for classification, showing that it meets the conditions of paragraph (g) of this section.

(2) The intermediary reviews the request and sends the request, with its recommendations, to HCFA.

(3) HCFA reviews the request and the intermediary's recommendation and forwards its approval or disapproval to the intermediary

(4) An approved classification as sole community HHA remains in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved.

(g) *Basis for classification as a sole community HHA.* HCFA approves a classification as a sole community HHA only if the HHA designates a particular area and shows that no other HHA provides services within that area.

[53 FR 6638, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988; 56 FR 8845, Mar. 1, 1991]

§ 424.24 Requirements for medical and other health services furnished by providers under Medicare Part B.

(a) *Exempted services.* Certification is not required for the following: (1) Hospital services and supplies incident to physicians' services furnished to outpatients. The exemption applies to drugs and biologicals that cannot be self-administered, but not to partial hospitalization services, as set forth in paragraph (e) of this section.

(2) Outpatient hospital diagnostic services, including necessary drugs and biologicals, ordinarily furnished or arranged for by a hospital for the purpose of diagnostic study.

(b) *General rule.* Medicare Part B pays for medical and other health services furnished by providers (and not exempted under paragraph (a) of this section) only if a physician certifies the content specified in paragraph (c)(1), (c)(4) or (e)(1) of this section, as appropriate.

(c) *Outpatient physical therapy and speech-language pathology services—*(1) *Content of certification.* (i) The individual needs, or needed, physical therapy or speech pathology services.

(ii) The services were furnished while the individual was under the care of a physician, nurse practitioner, clinical nurse specialist, or physician assistant.

(iii) The services were furnished under a plan of treatment that meets the requirements of § 410.61 of this chapter.

(2) *Timing.* The certification statement must be obtained at the time the plan of treatment is established, or as soon thereafter as possible.

(3) *Signature.* (i) If the plan of treatment is established by a physician,

nurse practitioner, clinical nurse specialist, or physician assistant, the certification must be signed by that physician or nonphysician practitioner.

(ii) If the plan of treatment is established by a physical therapist or speech-language pathologist, the certification must be signed by a physician or by a nurse practitioner, clinical nurse specialist, or physician assistant who has knowledge of the case.

(4) *Recertification*—(i) *Timing*. Recertification statements are required at least every 30 days and must be signed by the physician, nurse practitioner, clinical nurse specialist, or physician assistant who reviews the plan of treatment.

(ii) *Content*. The recertification statement must indicate the continuing need for physical therapy or speech-language pathology services and an estimate of how much longer the services will be needed.

(iii) *Signature*. Recertifications must be signed by the physician, nurse practitioner, clinical nurse specialist, or physician assistant who reviews the plan of treatment.

(d) [Reserved]

(e) *Partial hospitalization services: Content of certification and plan of treatment requirements*—(1) *Content of certification*. (i) The individual would require inpatient psychiatric care if the partial hospitalization services were not provided.

(ii) The services are or were furnished while the individual was under the care of a physician.

(iii) The services were furnished under a written plan of treatment that meets the requirements of paragraph (e)(2) of this section.

(2) *Plan of treatment requirements*. (i) The plan is an individualized plan that is established and is periodically reviewed by a physician in consultation with appropriate staff participating in the program, and that sets forth—

(A) The physician's diagnosis;

(B) The type, amount, duration, and frequency of the services; and

(C) The treatment goals under the plan.

(ii) The physician determines the frequency and duration of the services taking into account accepted norms of medical practice and a reasonable ex-

pectation of improvement in the patient's condition.

(f) *All other covered medical and other health services furnished by providers*—(1) *Content of certification*. The services were medically necessary.

(2) *Signature*. The certificate must be signed by a physician, nurse practitioner, clinical nurse specialist, or physician assistant who has knowledge of the case.

(3) *Timing*. The physician, nurse practitioner, clinical nurse specialist, or physician assistant may provide certification at the time the services are furnished or, if services are provided on a continuing basis, either at the beginning or at the end of a series of visits.

(4) *Recertification*. Recertification of continued need for services is not required.

[53 FR 6638, Mar. 2, 1988; 53 FR 12945, Apr. 20, 1988; 56 FR 8845, 8853, Mar. 1, 1991; 63 FR 58912, Nov. 2, 1998]

§ 424.27 Requirements for comprehensive outpatient rehabilitation facility (CORF) services.

Medicare Part B pays for CORF services only if a physician certifies, and the facility physician recertifies, the content specified in paragraphs (a) and (b)(2) of this section, as appropriate.

(a) *Certification: Content*. (1) The services were required because the individual needed skilled rehabilitation services;

(2) The services were furnished while the individual was under the care of a physician; and

(3) A written plan of treatment has been established and is reviewed periodically by a physician.

(b) *Recertification*—(1) *Timing*. Recertification is required at least every 60 days, based on review by a facility physician who, when appropriate, consults with the professional personnel who furnish the services.

(2) *Content*. (i) The plan is being followed;

(ii) The patient is making progress in attaining the rehabilitation goals; and,

(iii) The treatment is not having any harmful effect on the patient.